

Personal Professional and Inter Professional Practice

by Megan Ann Swift-Roberts

| | | | |
|----------------|---|-----------------|-------|
| FILE | 17994-1516_5580251_33394211_PERSONAL_PROFESSIONAL_AND_INTER_PROFESSIONAL_PRACTICE.DOCX (29.73K) | | |
| TIME SUBMITTED | 01-MAR-2016 09:20PM | WORD COUNT | 3254 |
| SUBMISSION ID | 53625599 | CHARACTER COUNT | 18908 |

In today's demographically ageing society, the prevalence of older adults with a cognitive impairment is increasing, it is therefore important nurses have the ability to assess capacity and be prepared to act as advocates for those who lack the capability to make decisions for themselves (Davis et al, 2011). This paper will discuss the legal, ethical and professional issues that may arise if decisions are to be made on behalf of a patient suffering from dementia. It will take in to consideration the relevant legislation, ethical frameworks and current guidelines available and debate topics such as therapeutic lying and covert medication and the application of these in a clinical setting. Throughout this essay, confidentiality and anonymity of the patient have been maintained and trust identifiers removed in adherence with the Nursing and Midwifery Council (NMC) Code of Conduct (2015). For the purpose of this essay the patient will be referred to as Mrs. Smith.

Case Study: Mrs. Smith was a 75 year old female who suffered from Alzheimer's disease. As a result she was often confused and disorientated, suffered memory loss and displayed repetitive behaviour. She had been admitted to hospital following a fall. On the morning drug round Mrs. Smith had begun to regularly refuse to take her medication which included warfarin for atrial fibrillation and levetiracetam for epilepsy. A decision was made to administer the medications covertly within her breakfast.

By law, medical staff are required to obtain valid consent before carrying out any intervention with a patient, including the administration of medication (GMC, 2013). The Department of Health (DOH) published guidance on consenting to medical procedures stating for consent to be valid, it must be 'given voluntarily by an appropriately informed person who has the capacity to consent' (DOH, 2009 p.9) to the proposed procedure. Mrs Smith had not been consenting to the medications therefore the nurses were unable to give them, however, the law states that every part of the definition must present before consent can be considered valid.

Under the Mental Capacity Act (MCA), in the first instance, everyone is presumed to have capacity; this protects the individual's autonomy and their right to make decisions. The act also states a person's decisions should be respected, even if they appear unwise (MCA, 2005). However, the healthcare team had become concerned about Mrs Smith's condition as she had begun to suffer seizures related to the omission of her epilepsy medication. After speaking to her close relatives, it was also noted there had been further decline in her mental functioning due to dementia over the past few weeks. This lead to an assessment of her capacity to consent to medication administration. The British Medical Association (BMA) identifies it must first be shown an individual has an impairment or disturbance of the mind such as cognitive decline associated with Alzheimer's disease (BMA, 2008) before an assessment can be performed. Mrs Smith had a formal and recognised

diagnosis of Alzheimer's disease therefore by law it was justified to carry out a capacity assessment.

An investigation can then be made in to the individual's decision making capacity using the four criteria laid out in the MCA. The individual must be able:

- (a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his decision (whether by talking, using sign language or any other means).

(MCA, 2005).

This evaluation was carried out on the ward by nursing and medical staff using these four criteria.

Mrs Smith did not meet any of the stated requirements and therefore was deemed not to have capacity. The MCA was created 'to protect and restore power to those vulnerable people who lack capacity' (Social Care Institute for Excellence, 2009). By acting under this legislation, it would prevent the ward staff from causing harm to the patient and also act as guidance for them when caring for a patient who lacks capacity.

The issue of how to administer Mrs. Smith's medication was then raised. NICE have created guidance on covert medication administration within nursing homes, however this can equally be applied to practice within a hospital setting. NICE states a 'best interests' meeting should be held with all relevant persons present including medical staff, nurses, a pharmacist and relatives of the patient to consider the matter (NICE, 2015). The team caring for Mrs. Smith ensured a meeting was held to discuss whether this method would be appropriate. What is in the 'best interests' of an individual will vary from person to person, the law gives a number of factors to consider when making this type of decision (Mental Health Foundation, 2015). The legal requirements for acting in a person's best interest outlined in the MCA are: to take in to account the person's past and present wishes, feelings, beliefs and values and any other factors that they would be likely to consider if they had capacity (MCA, 2005a). The act also requires those making the best interests decision to consult any persons previously named by the individual, anyone engaged in caring for the individual or a designated lasting power of attorney (MCA, 2005a). Mrs Smith had not appointed a formal lasting power of attorney however she had been cared for by her daughter from the onset of her Alzheimer's and had always discussed any past decisions with her. No one other than the patient can consent for any procedure however when this is not possible, the involvement of relatives and close friends may help to clarify the values of an individual and establish their best interests (National Health Service, 2010). After speaking to Mrs Smith's family it became apparent she had previously been in concordance with her medication regime and had taken her tablets regularly for years with good effect and no complaints. Her daughter was also concerned about her mother's health as her

epilepsy had been well controlled until she had recently stopped taking medication. The issue was to decide whether Mrs. Smith would consent to the medication had she been of sound mind. In review of Mrs. Smith's history it would appear to be a reasonable assumption she would be in agreement. Although involvement of relatives and close friends may be useful when making decision on behalf of a person who lacks capacity, it is important to respect their right to privacy and confidentiality (NMC, 2015). Mrs. Smith's case was only discussed with those directly involved in her care.

Following the meeting, a decision was made by the team to covertly administer the medication by disguising it in Mrs. Smith's breakfast. NICE (2015) states the method of covert administration of medications is only to be used under exceptional circumstances and must be made in line with the MCA 2005. The National Health Service (NHS) recognises this type of treatment as an option if it was to be used 'in order to prevent an individual from missing essential treatment' (NHS, 2010 p6). The NHS (2010a) state registered practitioners should reflect on treatment aims of disguising medication. The aim for the patient in this case would be to prevent continuation of the seizures she had been experiencing. Haw et al (2010) found covert administration to be to be common in older adults with dementia; however this process was not always carried out in accordance with appropriate legislation. They found healthcare professionals failed to discuss or document the administration method correctly. However, Mrs Smith's case was discussed amongst all relevant persons and documented within her care plans. It is a requirement in the NMC code of conduct (2015) that nurses are to keep accurate and clear records of any problems that have arisen and how they have been dealt with in order to provide colleagues with all significant information. In turn this would protect the patient and provide continuity of care.

It was also necessary to discuss how the medication would be incorporated in to Mrs. Smith's breakfast. The Southampton Medicines Advice Service (2015) argues altering the form of medicines for example crushing tablets is usually an unlicensed activity and would therefore be against the law. Involving a pharmacist in this decision would clarify the ability to change the form of Mrs Smith's medications. A recommendation was made to change both the levetiracetam and warfarin tablets to oral solutions which could then be given with food.

The National Institute for Health and Care Excellence (NICE) state when people with dementia lack capacity, decisions made under the MCA should be made in line with the accompanying code of practice (NICE, 2006). The accompanying code of practice is not legally binding but was formed as guidance for healthcare professionals working with patients who lacked capacity. The code of practice identifies section 5 of the MCA was created to protect those who were making best interests decision on behalf of a patient from liability, this covers giving of medication (MCA Code of

Personal Professional and Inter Professional Practice

Practice, 2007). Overall, the team had made legally sound decisions with regards to current legislation.

As registered professionals, nurses have a duty to adhere to the Nursing and Midwifery Council Code of Conduct (2015) to promote safe and effective practice. The NMC standards for medicines management considers covert administration of medication not to be good practice arguing the registrant must understand they are accountable for this decision (NMC, 2010). Professionally, the NMC code requires registrants to be open and honest and encourages veracity (NMC, 2015). Blythe (2000) describes covert medication as deception as although the nurse has not told lies to the patient, they have not informed them of the truth. The NMC too defines disguising medication in the absence of informed consent as deception and does not support this in practice (NMC, 2001).

Conversely, the NHS identifies this intervention may be justified 'if the treatment is necessary to in order to save life, prevent deterioration or ensure improvement in the individuals' physical and/or mental health' (NHS, 2010. p4). Mrs. Smith was experiencing epileptic seizures as a result of not taking her medication demonstrating a need to ensure improvement to her physical health.

Beauchamp and Childress (2001) created a well-known ethical framework based upon four main principles of autonomy, justice, beneficence and non-maleficence. The British Association for Counselling and Psychotherapy (BACP) believes ethical decisions that are supported by one or more of these principles without confliction from the others are reasonably well founded (BACP, 2015). However the BACP also acknowledge this is not always possible in every circumstance and to choose between principles may be required but this may not necessarily make the decision unethical (BACP, 2015). These principles can be applied to Mrs. Smith's situation. Autonomy is 'the respect for the client's right to be self-governing' (BACP, 2015). Collis (2006) identifies nurses often struggle to balance respecting a patients autonomy whilst also avoiding potential harm. Bensing (2000) says patient centred care relies heavily on patient participation in clinical decision making to gain their perspective and their needs and preferences. However, without capacity, it may be argued Mrs. Smith's dementia has undermined her autonomous decision to refuse treatment by affecting her judgement (BMA, 2008).

Beneficence is to promote the patients wellbeing and non-maleficence is to avoid harm to the patient (BACP, 2015). As discussed by Mitchell (2014), omitting the medications may reduce their beneficent effect in turn leading to maleficent practices as symptoms of the conditions they are treating return. The longer the period of time Mrs. Smith was left without the medications increased the likelihood of complications. Warfarin omission could lead to a cardiac event and omission of Levetiracetam had already begun to cause seizures. This could be reversed by her medication which the medical team chose to give by means of covert administration, however, these actions may be

considered paternalistic as the decision was made for Mrs. Smith by healthcare professionals who deemed it to be her best interests (Melia, 1989).

There are also many ethical issues surrounding the concept of therapeutic lying. Sperber (2015 p.43) describes therapeutic lying as 'the practice of deliberately deceiving patients for reasons considered to be in their best interests.' For Mrs. Smith this would mean withholding the truth about medication administration in her breakfast to prevent her seizures and risk of cardiac event. Kitwood (1997) disagrees with the uses of lies in dementia care arguing it undermines and degrades the person with dementia. However, research was conducted by Day et al (2011) with people in the early stages of dementia regarding their thoughts on lying in dementia care. Although the research may not be generalizable to every patient suffering from dementia, its findings showed people suffering from dementia may consider lying to be acceptable if told in their best interest (Day et al, 2011). Due to lack of NHS guidance on its use, nurses are discouraged from therapeutic lying to patients with dementia because of the potential legal implications (Culley, 2013). The Department of Health currently has no plans to provide guidance on therapeutic lying and states healthcare professionals should decide whether to use it on a case by case basis (Sprinks, 2013).

According to the NMC Code (2015), professionals are to act in the best interests of people at all times whilst adhering to all relevant laws surrounding mental capacity in those who lack capacity. Griffith (2015) emphasises the need to act in the best interests of patient is only required when it has been shown they lack capacity, he argues this limitation promotes autonomy and reduces paternalistic interference from medical staff. In Mrs Smith's case, a lack of capacity had been demonstrated, it was therefore deemed appropriate for a best interest decision to be made. When decisions are to be made on behalf of the individual they must be patient centred (NMC, 2015 GMC, 2013). Griffith (2014) argues the determination of best interests was previously a paternalistic analysis of the risks and benefits of treatment for a patient, however he states with the formation of mental capacity legislation this has now moved to a much more holistic approach which considers the beliefs and values of the patient. This was true for Mrs. Smith as a meeting was held to draw together all relevant information to make an informed decision about the care to be provided. This was made in line with current legislation and professional requirements.

NICE (2016) are currently developing new guidelines on the assessment, management and support for carers of people with dementia. Existing guidance states people with dementia should be encouraged to make choices regarding their care independently, however when this is not possible they should also have access to the necessary support needed to make these decisions (NICE, 2013). The NMC code (2015) states nurses are to act as advocates for their patients, this would mean ensuring their wishes are upheld and respected when deciding upon their care. Mrs. Smith was a

Personal Professional and Inter Professional Practice

vulnerable patient who lacked capacity; it was the aim of the healthcare staff in charge of her care to work within her best interests to maintain her health and wellbeing. This was achieved by bringing together a multidisciplinary team and taking a holistic approach to deciding what was in her best interests, with involvement of close relatives and friends playing a valuable role in the decision making process. On reflection, it may have been useful for Mrs. Smith to have created an advanced care plan detailing her wishes regarding treatment if she became unable to make them herself. This would act as further guidance for the healthcare team when deciding on the patients care.

Reflecting on my own personal learning from this scenario, I have developed knowledge surrounding the required legal procedures when a person lacks capacity. I also understand that best interest decisions are to be made on an individual basis taking in to account the persons current and past preferences, feelings and attitudes. Forming decisions in this way and involving a multidisciplinary team works towards achieving more person centred care.

In conclusion, legally the medical team's decision was in keeping with current laws and the Mental Capacity Act however from a professional stance, the NMC generally does not support the practice of covert medication. The methods of covert administration of medication and therapeutic lying to patients raises many ethical issues however it is important to remember these cannot always be avoided when working in the best interests of the patient.

References:

Bensing, J. 2000. Bridging the Gap. The Separate Worlds of Evidence based Medicine and Patient Centred Medicine. Patient Education and Counselling 39, p17–25

Blythe J (2000) Study questions ethics of covert medication. British Medical Journal. 321, 7258, 40
British Association for Counselling and Psychotherapy. (2015). Ethical principles of counselling and psychotherapy. Available: http://www.bacp.co.uk/ethical_framework/ethics.php. Last accessed 22nd Feb 2016

British Medical Association. (2008). Ethics Tool Kit for Students. Available:
<http://www.bma.org.uk/support-at-work/ethics/medical-students-ethics-tool-kit/consent-to-treatment-lacking-capacity>. Last accessed 7th Feb 2016

Collis, SP. (2006). The importance of truth-telling in healthcare. Nursing Standard. 20 (17), p41-45

Culley, H. (2013). Therapeutic lying in dementia care. Nursing Standard. 28 (1), p35-39

Davis, N et al (2011). Learning Skills for Nursing Students. Exeter: Short Run Press. p17

Day, A and James, I and Meyer, T and Lee, D. (2011). Do people with dementia find lies and deception in dementia care acceptable? Aging and Mental Health. 15 (7), p822-829

Department of Health (2007). Mental Capacity Act Code of Practice. Norwich: The Stationary Office. p94-95

Department of Health. (2005). Mental Capacity Act: Inability to make decisions. Available:
<http://www.legislation.gov.uk/ukpga/2005/9/section/3>. Last accessed 7th Feb 2016

Department of Health. (2005). Mental Capacity Act: Best Interests. Available:
<http://www.legislation.gov.uk/ukpga/2005/9/section/4> . Last accessed 7th Feb 2016

Department of Health (2009). Reference guide to consent for examination or treatment . 2nd ed. London: The Department of Health. p9

General Medical Council. (2013). Consent Guidance: Making decisions when a patient lacks capacity. Available: http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_making_decisions_patient_lacks_capacity.asp
Last accessed 7th Feb 2016

Griffith, R. (2014). Best interests of adults who lack capacity part 1: key concepts. British Journal of Nursing. 23 (22), p1220-1221

Griffith, R. (2015). Understanding the Code: acting in a patient's best interests. British Journal of Community Nursing. 20 (9), p458-461

Personal Professional and Inter Professional Practice

Haw, C and Stubbs, J. (2010). Covert administration of medication to older adults: a review of the literature and published studies. *Journal of Psychiatric and Mental Health Nursing*. 17, 761-768

Kitwood, T (1997) *Dementia Reconsidered: The Person Comes First*. Open University Press, Buckingham

Melia, K (1989). *Everyday Nursing Ethics*. Basingstoke: The Macmillan Press Ltd.

Mitchell, G. (2014). Therapeutic lying to assist people with dementia in maintaining medication adherence. *Nursing Ethics*. 21 (7), p844-849

National Health Service. (2010a). Guidance on Covert Medication. Available:

<http://www.humber.nhs.uk/Downloads/Services/Pharmacy/Guidelines/Covert%20medication%20guidance%20in%20HFT.pdf>. Last accessed 22nd Feb 2016

National Health Service. (2010). Guidance on Covert Medication. Available:

<http://www.humber.nhs.uk/Downloads/Services/Pharmacy/Guidelines/Covert%20medication%20guidance%20in%20HFT.pdf>. p6. Last accessed 22nd Feb 2016

National Institute for Health and Care Excellence. (2013). *Dementia: Independence and Wellbeing*.

Available: <https://www.nice.org.uk/guidance/QS30/chapter/Quality-statement-2-Choice-and-control-in-decisions>. Last accessed 15th Feb 2016

National Institute for Health and Care Excellence. (2015). *Medicines management in care homes*.

Available: <https://www.nice.org.uk/guidance/qs85/chapter/quality-statement-6-covert-medicines-administration>. Last accessed 16th Feb 2016

Nursing and Midwifery Council (2010). *Standards for Medicines Management*. London: NMC. p32

Nursing and Midwifery Council (2015). *The code: professional standards of practice and behaviour for nurses and midwives*. London: NMC

Social Care Institute for Excellence. (2009). *Mental Capacity Act 2005 at a glance*. Available:

<http://www.scie.org.uk/publications/atagance/atagance05.asp>. Last accessed 22nd Feb 2016

Southampton Medicines Advice Service. (2015). What legal and pharmaceutical issues should be considered when administering medicines covertly?. Available:

<https://www.evidence.nhs.uk/document?ci=http%3a%2f%2fwww.medicinesresources.nhs.uk%2fGetDocument.aspx%3fpagelid%3d759623%3ffromsource%3dnelm&returnUrl=Search%3fq%3dcovert%2badministration%2bof%2bmedica>. Last accessed 16th Feb 2016

Sperber, M. (2015). Therapeutic lying: a contradiction in terms. *Psychiatric Times*. p43-47

Sprinks, J. (2013). Therapeutic lying should be avoided. *Nursing Older People*. 25 (8), p7